

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 469

CERTIFICATE OF DEATH

11388

Reg. Dist. No. 2330

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WorcesterCity or town Ocean City
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Aydelotte, Mr. Philander Andrews

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Divorced

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Dec. 20, 1871

8. AGE:

Years

Months

Days

If less than one day

75

hrs.

min.

9. Birthplace

Cedartown, W. Va. Md.
(Town, county, and state)

10. Usual occupation

Laborer - Fisherman

11. Industry or business

Davis-Lynch Fish Co.

MOTHER FATHER

12. Name

Joseph Aydelotte

13. Birthplace

Maryland

14. Maiden name

Leah Jane Currier

15. Birthplace

Maryland

16. Informant

Mrs. Joe Aydelotte

Address

Berlin Md

17.

(Burial, cremation, or removal, Which?)

Date thereof

11/9/46

(month) (day) (year)

Cemetery or crematory

Evergreen

Location

Berlin Md

18. Funeral director

Dr. H. D. Burkay

Address

Berlin Md

19.

(Filed by registrar)

19.

46.

Thos. J. E. Johnson

Registrar

Address

Salisbury

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6, 1946 at 6 ³⁵ _P ^M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 20, 1946 to Nov. 6, 1946and that I last saw him alive on Nov. 6, 1946

Immediate cause of death

Systemic Distraction from
extensive Tumor 3 months

DURATION

Due to

Dev. Cancer of pancreas

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Jack K. Williams MD

M. D. or other

Address

SalisburyDate signed 11-7-46

Permanently

ARTERIAL CENTER

NO CONTENT

RECEIVED
NOV 22 1946
BUREAU V.B.
2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County *Wicomico*
 City or town *Salisbury Ch. Hospital*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *md* County *Wic*City or town *Pittsville*
 (If outside city or town limits, write RURAL and give nearest town)Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Archie Samuel Baker

3. (b) Social Security Number

213-22-8296

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male *white* *Married*

8. (b) Name of husband or wife *Josephine Southern Shockley*6. (c) If alive, give age *69* years7. Birth date of deceased (mo., day, yr.) *Oct 12 1870*

8. AGE: Years Months Days If less than one day
76 *1* *6* _____ hrs. _____ min.

9. Birthplace *Roxanna Del.*
 (Town, county, and state)10. Usual occupation *State Road Commission*

11. Industry or business

12. Name *Seth Baker*13. Birthplace *Del.*14. Maiden name *Nancy Carey*15. Birthplace *Del.*16. Informant *Sadie Mae Foskey*Address *Eastport N. Y. River Ave.*17. *Burial* Date thereof *Nov. 21st 1946*
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *M. E. Cemetery*Location *Delmar Delaware*19. Funeral director *Wm. Howard Wells*Address *Pittsville md.*19. *11/20/46* 19. *46* *Barriett E. Johnson*
 (Date recd by Registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *November 18th* 19. *46* at *4 P* M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Nov. 2* to *Nov. 18*and that I last saw him alive on *Nov. 18* 19. *46*Immediate cause of death *Cardiac failure*Due to *Arteriosclerotic C-V-R disease*Due to *Diabetes mellitus*

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *William R. Gray, M.D.*Address *Salisbury, Md.* Date signed *11/20/46*

RECEIVED

NOV 27 1946

BUREAU V S.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-6)

CERTIFICATE OF DEATH

Reg. Dist. No.

3370

1. PLACE OF DEATH:

County WICOMICOCity or town NANICORE
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 54 years

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicCity or town Nanicoke
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

HARRY COLUMBUS BARCLAY

3. (b) Social Security Number

none

4. Sex

MALE COLORED

5. Color or race

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife CINDERELLA BARCLAY6. (c) If alive, give age 54 years

7. Birth date of

deceased (mo., day, yr.)

JAN 3, 1892

8. AGE:

Years

Months

Days

If less than one day

54105

hrs.

min.

9. Birthplace NANICORE, MD., WICOMICO
(Town, county, and state)

10. Usual occupation

farmer

11. Industry or business

MOTHER FATHER

12. Name

James Barclay

13. Birthplace

Nanicoke

14. Maiden name

Maria Jones

15. Birthplace

Nanicoke

16. Informant

Minnie Gertrude Perry

Address

Nanicoke Md.17. burial
(Burial, cremation, or removal, Which?)Date thereof Nov. 29, 1946
(month) (day) (year)

Cemetery or crematory

Nanicoke Cemetery

Location

Nanicoke, Md.

18. Funeral director

Dachill Funeral Home

Address

Princess Anne, Md.19. Nov 29 19 46
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 19 46, at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 14 19 46, to November 21 19 46and that I last saw him alive on November 21 19 46

Immediate cause of death

Cowdery Throat Lesion

DURATION

Due to

Due to

Other conditions

Angina of Liver

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William F. Farris

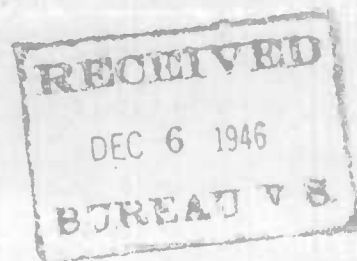
M. D. or other

Address

Helene - Md.Date signed Nov 22-46

Dr. Enrick

white - Nelson



2-35

with

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11391

Reg. Dist. No. 333

1. PLACE OF DEATH: Worcester
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 days
 Hospital, institution, or street address where death occurred:
Salisbury Peninsula General Hosp.
 How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
Maryland County Worcester
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME Annie Bayne

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed or divorced Married

8. (b) Name of husband or wife Noah Bayne

7. Birth date of deceased (mo., day, yr.) March 15-1888 6. (c) If alive, give age 60 years

8. AGE: Years 58 Months 7 Days 11 If less than one day
hrs.min.

9. Birthplace Rural Pocomoke, Worcester Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name George Triagle

13. Birthplace Maryland

14. Maiden name Betty Howell

15. Birthplace Maryland

16. Informant Noah Bayne

Address Rural Pocomoke Md

17. Burial Date thereof Apr 11, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wardtown Cemetery

Location Rural Pocomoke Md

18. Funeral director Henry H. Hutton

Address Pocomoke Md

19. 11/11/46 1946 Registrar Harriet E. Johnson
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1946, at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov 1 1946 to Nov 9 1946
 and that I last saw her alive on Nov 9 1946

Immediate cause of death Acute Cardiac failure

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 9 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

Signature Harriet E. Johnson
 M. D. or other

Address Salisbury Md Date signed 11-11-46

NOV 22 1946
BUREAU OF

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11392

Reg. Dist. No. 2230

1. PLACE OF DEATH:

County Wicomico
 City or town Fruitland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 69 years
 Hospital, institution, or street address where death occurred:
Salisbury, Md. R. D. I
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Fruitland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Salisbury, Md. R.D. I
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Leonard Bounds

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced mairred
 6. (b) Name of husband or wife Minnie I. Bounds
 6. (c) If alive, give age 67 years
 7. Birth date of deceased (mo., day, yr.) Feb. 16, 1877
 8. AGE: Years 69 Months 9 Days 9 If less than one day
69 hrs. 9 min.

9. Birthplace Wicomico Co. Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name James Bounds

13. Birthplace Wicomico Co. Md.

14. Maiden name Anna Marie White

15. Birthplace Wicomico Co. Md.

16. Informant Claude L. Bounds

Address Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/27/46
 (month) (day) (year)

Cemetery or crematory Allen Cemetery

Location Allen, Md.

18. Funeral director The Hill & Johnson Co.

Address Salisbury, Md.

19. 11/27/46 (Date rec'd by registrar) 19. 46 Registrar W. L. Johnson

MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov. 25, 1946 19. 1.30P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 46 19. 46 to Nov. 24/46 19. 46
 and that I last saw him alive on 11-24-46 19. 46

Immediate cause of death Cerebral Hemorrh. DURATION 2 wks.

Hypertension -

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature L. L. Lawry M. D. or

Address Fruitland Date signed 11-26-46

RECEIVED

DEC 10 1946

BUREAU VS

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11393

CERTIFICATE OF DEATH

Reg. Dist. No. 393

1. PLACE OF DEATH:

County WicomicoCity or town Parmontburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County WicomicoCity or town Parmontburg
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D. #1
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Marie Jane Brittingham

3. (b) Social Security Number

4. Sex

female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ernest S. Brittingham

7. Birth date of deceased (mo., day, yr.)

Nov. 25th 18736. (c) If alive, give age 76 years

8. AGE:

Years 72 Months 11 Days 12 If less than one day

9. Birthplace

R.D. Parmontburg Md.
(Town, county, and State)

10. Usual occupation

House wife

11. Industry or business

at home

FATHER

12. Name

Geo. Washington White

13. Birthplace

R.D. Parmontburg Md.

MOTHER

14. Maiden name

Katherine Elizabeth Smith

15. Birthplace

R.D. Parmontburg Md.

16. Informant

Miss Myrtle Brittingham

Address

R.D. Parmontburg, Md.

17. Burial

First Church Cem.

Cemetery or crematorium

Near Whiteville Del.

Location

Holloway & Co. Walter R. Holloway

18. Funeral director

Salisbury Maryland

Address

11/10/46

U.S. DEPARTMENT OF THE ARMY
JUL 22 1946
DURHAM T.B.
2-55

PLEASE, WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

11394

Reg. Dist. No. 9330

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. Coe. Naylor & Brown st.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME

Benjamin Roland Calloway

3.(b) Social Security Number

4. Sex

Male

5. Color of hair

White

6.(a) Single, married, widowed, or divorced

Widower

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1st 1946, at 8 P. M.

6.(b) Name of husband or wife

Sallie Harmon Calloway

7. Birth date of deceased (mo., day, yr.)

June 12 4 18836.(c) If alive, give age Dead years

8. AGE:

Years 63 Months 4 Days 19 If less than one day

9. Birthplace

Salisbury Maryland
(Town, county, and state)

10. Usual occupation

Machinist at

11. Industry or business

R.O. Brien & sons G. shop.

FATHER

12. Name Charles Edward Calloway

13. Birthplace

Lussex Co. Delaware

MOTHER

14. Maiden name Nancy Elliott

15. Birthplace

Salisbury Maryland

16. Informant

Mr. Roland B. Calloway

Address

227 Newton St. Salisbury MD

17. Burial

(Burial, cremation, or removal, which?) Nov. 4-1946

Cemetery or crematory

Palmer Cem.

Location

Salisbury Maryland

18. Funeral director

Hillman & G. Walter R. Hillman

Address

Salisbury Maryland

19.

(Date rec'd by registrar) 11/4/46

that death occurred on the date above stated; that I attended deceased from

and that I last saw him Medical Examiner Certificate alive on 19

Immediate cause of death

Coronary thrombosis sudden

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

21. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Injured at work?

23. SIGNATURE

Oliver Fisher M.D.Address Salisbury Md Date signed 11/2/46

RECEIVED

JUN 25 1946

U.S. DEPT. OF JUSTICE

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 126

CERTIFICATE OF DEATH

11395

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days - 22 hrs
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 20 days - 22 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Delaware County Surrey
City or town Millston Delaware
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

Coffin, Mrs. Nora E.

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife William J. Coffin
8.(c) If alive, give age 87 years
7. Birth date of deceased (mo., day, yr.) 1894
8. AGE: Years 72 Months _____ Days _____ It less than one day _____ hrs. _____ min.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22 19 46 at 5P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/1 19 46 to 11/22 19 46
and that I last saw him alive on 11/22 19 46
Immediate cause of death fall from
intestinal obstruction
Due to acute myocardial
infarction
Due to _____
Other conditions _____
(Include pregnancy within 8 months of death)
Major findings of operations None Date of op. 11/2/46
Autopsy results 11/2/46
PHYSICIAN: Please underline the cause to which death should be charged statistically.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business _____
12. Name Joseph D. Coffin
13. Birthplace Maryland
14. Maiden name Sophia Wilson
15. Birthplace Maryland
16. Informant Joseph D. Coffin
Address Margela St. Ind. Rd.
Salisbury Date of report NOV. 25 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mechanics Cemetery
Location Millston, DE
18. Funeral director H.B. Johnson
Address Millston DE
19. 11/26 19 46 Barrett D. Johnson
(Filed by registrar) (month) (day) (year) Registrar

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ✓ Date of _____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____
23. SIGNATURE J. H. Hub M. D. or other _____
Address Salisbury Date signed 11/23/46

MARGIN RESERVED FOR BINDING

VS-A15 9-45-NM

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 10 1946
BUREAU T. S.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11396

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County Wicomico County
 City or town Salisbury Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 1/2 years
 Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wicomico
 City or town Salisbury Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 196 3rd Street
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Emory Alfred Collins

3. (b) Social Security Number _____

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Male White Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Oct 26 1893
 6. (c) If alive, give age _____ years

8. AGE: Years Months Days If less than one day
53 1 26 _____ hrs. _____ min.

9. Birthplace Snow Hill Md.

(Town, county, and state).

10. Usual occupation Truck Driver11. Industry or business none12. Name Signey Rockaway13. Birthplace Snow Hill Md.14. Maiden name Jarvis Collins15. Birthplace Snow Hill Md.16. Informant Catherine CaylessAddress Quantico Rd. Route #2

17. Burial Date thereof Nov 27 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Hawthorn Cem.Location Salisbury Md Snow Hill Md18. Funeral director Booker WeekAddress 404 Lake St.19. 11/27 19 46 Barriett E. Johnson

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 19 46, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Medical Examiner's Certificate
 and that I last saw him alive on 11/22 19 46

Immediate cause of death _____

Suicidal wound of Head sudden

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Examination of Brain (Bullet wound)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

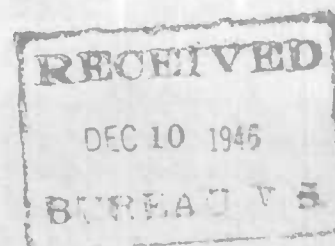
Accident, suicide, or homicide Homicide Date of 11/22 46Where did injury occur? Salisbury Wicomico Md

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) Public placeMeans of injury Suicidal wound Injured at work? no23. SIGNATURE Clara E. Fisher MDAddress Salisbury Md Date signed 11/27 46



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1248

CERTIFICATE OF DEATH

Reg. Dist. No. 3530

1. PLACE OF DEATH:

County... *Salisbury*City or town... *Salisbury*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For noninstitutional give residence of mother)

State... *MD* County... *Salisbury*City or town... *Salisbury*
(If outside city or town limits, write RURAL and give nearest town)Street No... *R.D. #3*
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

George Oliver Collins

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mamie E. Collins

7. Birth date of deceased (mo., day, yr.)

June 4-1886

6. (c) If alive, give age

54 years

8. AGE:

Years *60* Months *4* Days *29* If less than one day

9. Birthplace

near Georgetown Del
(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

Farmer

12. Name

Elias J. Collins

13. Birthplace

Summers, Del.

14. Maiden name

Mary Dunn

15. Birthplace

Summers, Del.

16. Informant

Mrs. Mamie E. Collins

Address

R.D. #3 Salisbury Md.

17. Burial

Buried

(Burial, cremation, or removal, which?)

Salisbury Md.

Cemetery or crematory

Salisbury Md.

Location

Salisbury Md.

18. Funeral director

Walter R. Hall

Address

Salisbury Md.

19. (Date rec'd by registrar)

11/5/46

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 3rd 1946 at *7:40p* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 28, 1946 to *November 1, 1946*and that I last saw him alive on *November 1, 1946*Immediate cause of death *Cirrhosis of Liver*

DURATION

2 mo. 5 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. J. Rose M.D. or otherAddress *Salisbury Md.* Date signed *11/6/46*

RECEIVED

NOV 25 1946

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-6)

CERTIFICATE OF DEATH



11398

Reg. Dist. No. 3300

1. PLACE OF DEATH: Wicomico
 County Wicomico
 City or town Mardela, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 months
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Wic.
 City or town Mardela, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) if veteran, name war _____

3. (a) FULL NAME Mark H. Cooper

3. (b) Social Security Number

4. Sex M 5. Color of race White 6. (a) Single, married, widowed, or divorced Married
 B. (b) Name of husband or wife Mary E. Cooper

7. Birth date of deceased (mo., day, yr.) May 31 1892
 (c) If alive, give age _____ years

8. AGE: Years 54 Months 5 Days 20 If less than one day _____ hrs. 55 min.

9. Birthplace Delmar, DE Sussex, Del.
 (Town, county and state)

10. Usual occupation Lumber Mill Owner

11. Industry or business _____

FATHER 12. Name John S. Cooper

13. Birthplace Del.

MOTHER 14. Maiden name Belia Taylor

15. Birthplace Md.

16. Informant Mary E. Cooper

Address Mardela, Md.

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof 11 24 1946
 (month) (day) (year)

Cemetery or crematory Mardela

Location Mardela, Md.

18. Funeral director Graves Bros

Address Sharptown, Md.

19. 11/24/46 (Date rec'd by registrar) _____ Registrar W. H. Roberts

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1946 at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1946 to Nov 20 1946
 and that I last saw him alive on Nov 19 1946

Immediate cause of death Myocardial infarction
by extra

Due to obstruction of lungs

Due to Arteriosclerosis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. H. Roberts

M. D. or other _____

Address Delmar, Del. Date signed Nov 21/46

RECEIVED

DEC 3 1946

BUREAU V.B.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95d

CERTIFICATE OF DEATH

11399
Reg. Dist. No. 2330

1. PLACE OF DEATH: *Wicomico*
County.....
City or town..... *Pittsville*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... *50 yrs*
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... *md* County..... *Wicomico*
City or town..... *Pittsville*
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME *Thenerietta Serman Davis* 3. (b) Social Security Number

4. Sex *Female* 5. Color or race *white* 6.(a) Single, married, widowed, or divorced *Widowed*
6.(b) Name of husband or wife..... *John Davis*
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) *January 17 1862*
8. AGE: Years *84* Months *9* Days *24* If less than one day hrs. min.

8. Birthplace..... *Campbelltown Md*
(Town, county, and state)

10. Usual occupation.....

11. Industry or business *Housework*

12. Name..... *George Campbell*

13. Birthplace..... *Campbelltown Md*

14. Maiden name..... *Margaret Campbell*

15. Birthplace..... *Campbelltown Md*

18. Informant..... *Irene Thudson*

Address..... *Willards Md*

17. *Burial* Date thereof..... *Nov 13 1946*
(Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory..... *Pittsville Md*

Location..... *Pittsville Md*

18. Funeral director..... *Wm. Howard Neelst.*

Address..... *Pittsville Md.*

19. *11/13* 19 *46* Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION
20. DATE OF DEATH..... *Nov 11, 1946* 19..... at *10 A M*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *March 1946* to *day of death* and that I last saw him alive on *11-11-46* 19.....

Immediate cause of death..... *Chronic myocarditis* DURATION *1 yr.*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Antopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... *Frank R Lewis M.D.* M. D. or other

Address..... *Willards Md.* Date signed..... *11-12-46*

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 27 1946

BUREAU V &

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11480

3510

1. PLACE OF DEATH:
 County Wicomico
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State MD County Wicomico
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME Mitchell James Davis

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (n) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Name Wallace Davis

7. Birth date of deceased (mo., day, yr.) July 22, 1869 8. (c) If alive, give age 63 years

8. AGE: Years 77 Months 3 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Madison, Worcester Co. Md.
(Town, county, and state)10. Usual occupation Retired11. Industry or business Section Foreman, Penn. R.R.12. Name James Davis13. Birthplace Madison, Md.14. Maiden name Delora Davis15. Birthplace Madison, Md.16. Informant Mrs. Edna WhiteAddress Bethesda, Md.17. Burial Date thereof 11/4/46
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Greenhill CemeteryLocation Madison, Md.18. Funeral director David H. MeachamAddress Bethesda, Md.19. Nov 14 1946 Mrs J M Wallap
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1946 at 1:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 4, 1946 to November 11, 1946 and that I last saw him alive on November 8, 1946
 Immediate cause of death Cardiac Failure

DURATION

Due to Arteriosclerotic Heart Disease

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert Fox MD M. D. or otherAddress Dartmouth, Md. Date signed Nov. 14, 1946



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

CERTIFICATE OF DEATH

Reg. Dist. No. 9390

1. PLACE OF DEATH:

County Wilcomila
 City or town Salisbury 2nd
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Wilcomila
 City or town Salisbury 2nd
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 297 leathers
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex Female 5. Color or race a.a. 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Joshua Dixon
 7. Birth date of deceased (mo., day, yr.) June 25 1869
 8. AGE: Years about 77 Months - Days - If less than one day - hrs. - min.

9. Birthplace Allen 2nd
 (Town, county, and state)

10. Usual occupation lived with Daughter

11. Industry or business Same as above

12. Name Charles Carson

13. Birthplace Allen 2nd

14. Maiden name Heater

15. Birthplace Allen 2nd

16. Informant Rufus Washell

Address Salisbury 2nd

17. Burial, cremation, or removal, Which? Burial Date thereof Nov - 6 - 1946

(month) (day) (year)

Cemetery or crematory Haverton

Location Salisbury md

18. Funeral director James H. Stewart

Address Salisbury md

19. 11/6/46 1946

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2 1946 at 7:00A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1946 to Sept 2 1946
 and that I last saw her alive on Sept 2 1946

Immediate cause of death Arteriosclerotic heart disease

DURATION

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE E.A. Farnell

M. D. or other

Address 604 W. main St.

Date signed 11-5-46

RECEIVED

NOV 25 1946

ST. LOUIS

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

11402

Reg. Dist. No. 3390

1. PLACE OF DEATH:

County Worcester
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Snow Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Drummond Baby Boy

3. (b) Social Security Number

4. Sex Male 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Single

B. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Nov. 13/46 8. (c) If alive, give age _____ years

8. AGE: Years _____ Months _____ Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Salisbury, Maryland (Worcester)
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Hodson Harmon

13. Birthplace Maryland

14. Maiden name Betty Ann Drummond

15. Birthplace Maryland

16. Informant Blana Aydelitte

Address Snow Hill, Md

17. Burial Date thereof Nov. 18/46
 (Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Greenwood

Location Snow Hill, Md

18. Funeral director Wiley C. Dennis

Address Snow Hill, Md

19. 11/18/46 19 46 Harriet B. Johnson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 19 46, at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/13/46 19 _____ to 11/17/46 19 _____
 and that I last saw him alive on 11/17/46 19 _____

Immediate cause of death Crematury DURATION Small birth

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul Cohen M.D.

M. D. or other _____

Address Snow Hill Date signed 11/18/46

RECEIVED

NOV 27 1946

BUREAU V.B.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 173

CERTIFICATE OF DEATH

Reg. Dist. No. 3390

1. PLACE OF DEATH:

County... ShiomiCity or town... Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Months

Hospital, institution, or street address where death occurred:

415 Adams St.How long in hospital or institution? Months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Connecticut County... FairfieldCity or town... Meriden
(If outside city or town limits, write RURAL and give nearest town)Street No. 76 West Ave
(If rural, give LOCATION) ✓

2(c) If veteran, name war... ✓

3. (a) FULL NAME

Annie Bell Edwards

3. (b) Social Security Number

✓

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Frank Burr Edwards6. (c) If alive, give age 88 years7. Birth date of deceased (mo., day, yr.) Nov. 21, 18688. AGE: Years 77 Months 11 Days 5 If less than one day9. Birthplace Viceland, New Jersey
(Town, county, and state)10. Usual occupation at home11. Industry or business V12. Name Samuel Frederick13. Birthplace New Jersey14. Maiden name Frances Metting15. Birthplace New Jersey16. Informant Mrs. Evelyn FiechterAddress Pittsville, Md.17. Burial Date thereof 11/29/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Lawson, Conn.Location De Witt Johnson Co.18. Funeral director De Witt Johnson Co.Address Pittsville, Md.19. 11/29/46 Registrar Harriet E. Johnson
(Date read by registrar) (month) (day) (year)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 19 46 at 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Nov. 26 19 46Immediate cause of death chronic hypertensive nephritisDue to chronic myocarditisOther conditions chronic arteriosclerosisMajor findings of operations noAutopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: noAccident, suicide, or homicide... Date of... no

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Frederick RegistrarAddress Pittsville, Md. Date signed 11/28/46

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 10 1946

B-FLA-1

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11404

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:
 County... Wicomico
 City or town... Salisbury, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... Since Oct. 26, 1946
 Hospital, institution, or street address where death occurred:
Eastern Shore Tuberculosis Sanatorium
 How long in hospital or institution?... Since Oct. 26, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Maryland County... Garoline
 City or town... Federalburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...
 (If rural, give LOCATION) ✓
 2(a) If veteran, name war...

3. (a) FULL NAME
Eskridge, Reuben Prendiville

3. (b) Social Security Number
222-10-6111

4. Sex... Male 5. Color or race... White 6. (a) Single, married, widowed, or divorced... Married
 6. (b) Name of husband or wife... Marion L. Small Eskridge
 6. (c) If alive, give age... 38 years
 7. Birth date of deceased (mo., day, yr.)... May 30, 1904
 8. AGE: Years... 42 Months... 5 Days... 16 It less than one day... hrs. min.

9. Birthplace... Bethel, Delaware
 (Town, county, and state)

10. Usual occupation... Mechanic

11. Industry or business

12. Name... Nora Prendiville

13. Birthplace... Concord, Del.

14. Maiden name... Oakley Thomas Eskridge

15. Birthplace... Bethel, Del.

16. Informant... self

Address

17. (Burial, cremation, or removal - Which?) Date thereof... 11-20-46
 (month) (day) (year)

Cemetery or crematory... Bethel Cemetery

Location... Bethel, Del.

18. Funeral director... Reginald Cooper

Address... 11/20/46

19. (Date rec'd by registrar) 11/20/46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Nov. 16, 1946, 11:45p. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Oct. 26, 1946, to Nov. 16, 1946
 and that I last saw him alive on Nov. 16, 1946

Immediate cause of death... Pulmonary Tuberculosis
 DURATION... 10 week

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Paul M. D. or other

Address... Snow Hill, Md. Date signed... 11/18/46

RECEIVED
DEC 10 1946
BUREAU

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 72

CERTIFICATE OF DEATH

Reg. Dist. No. 11405 3930

1. PLACE OF DEATH:

Cenely..... Wicomico
 City or town..... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 18 Years
 Hospital, institution, or street address where death occurred:
110 North Division St.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Wicomico
 City or town..... Salisbury Rural..... 3
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Ocean City Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

Kenneth M. Fletcher
 4. Sex..... male 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... married
 6. (b) Name of husband or wife..... Mildred Carrow Fletcher
 6. (c) If alive, give age..... 35 years
 7. Birth date of deceased (mo., day, yr.)..... April 17, 1909.
 8. AGE: Years..... 37 Months..... 6 Days..... 28 If less than one day..... hrs. min.

9. Birthplace..... Westminster, Carroll, Md.
 (Town, county, and state)

10. Usual occupation..... Barber

11. Industry or business.....

FATHER 12. Name..... Lewis F. Fletcher

13. Birthplace..... Maryland.

MOTHER 14. Maiden name..... Effie M. Shirver

15. Birthplace..... Pennsylvania

16. Informant..... Mrs. Kenneth M. Fletcher

Address..... Salisbury, Maryland. R. D. 3

17. Burial..... Burial Date thereof..... Nov. 17, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Shad Point Cemetery

Location..... Shad Point, Maryland.

18. Funeral director..... The Hill & Johnson Co.

Address..... Salisbury, Maryland.

19. 11/20 1946 Harriet E. Johnson Registrar
 (Date rec'd by registrar) (month) (day) (year) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 14, 1946 19..... 46 P..... 46

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19..... 40 to..... Nov 14 19..... 46
 and that I last saw him alive on..... Nov 14 19..... 46

Immediate cause of death..... Coronary thrombosis

Due to.....

Due to.....

Other conditions..... Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Harriet E. Johnson M. D. or other

Address..... Salisbury, Md. Date signed..... 11-20-46

RECEIVED

DEC 10 1946

BUREAU

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11406

CERTIFICATE OF DEATH

Reg. Diat. No. 3330

1. PLACE OF DEATH

County BaltimoreCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
P.O. #1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. P.O. #1
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Warren Duane Foorke

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1946 at 6:30 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Nov. 1 1945 to Nov. 25 1946and that I last saw him alive on Nov. 24 1946Immediate cause of death Cerebral HemorrhageDue to Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Signature Lu L. LawryAddress 11/26/46

Date signed

6. (b) Name of husband or wife

Mary E. Foorke

7. Birth date of deceased (mo., day, yr.)

Sept. 15 - 18676. (c) If alive, give age 71 years

8. AGE:

Years 79 Months 2 Days 10 If less than one day

hrs. min.

9. Birthplace Worcester Co. Md.

(Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

12. Name William Foorke13. Birthplace Worcester Co. Md.14. Maiden name Elizabeth Wyden15. Birthplace Worcester Co. Md.16. Informant Mrs. Mary E. FoorkeAddress P.O. #1, Salisbury Md.17. Burial (Burial, cremation, or removal, which?) BurialDate thereon Nov. 27-46

(month) (day) (year)

Cemetery or crematory Baltimore Cem.Location Salisbury Md.18. Funeral director Walter R. TottenAddress Salisbury Maryland

19. (Date held by registrar)

1946Registrar Barrie L. JohnsonAddress Salisbury

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 10 1946

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2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17008

11407

CERTIFICATE OF DEATH

Reg. Dist. No. 9330

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Penninsula Funeral HospitalHow long in hospital or institution? 4.8 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Packwood Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Hale Silliman Mae

3. (b) Social Security Number

4. Sex Female5. Color or race C6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 9, 19288. AGE: Years 18 Months 4 Days 9 If less than one day _____ hrs. _____ min.9. Birthplace Salisbury, Wicomico Md.
(Town, county, and state)10. Usual occupation None11. Industry or business None12. Name William Hale13. Birthplace Packwood Md.14. Maiden name Lillie Jackson15. Birthplace Quantico Md.16. Informant William HaleAddress Belton Rt #2 Md.17. Burial Date thereof 11/21/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Packwood Md.Location Packwood Cemetery18. Funeral director Liquid R. SpencerAddress Salisbury, Md.19. 11/21 19 46 Barriett J. Johnson
(Entered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1946 at 6:18 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____

and that I last saw him alive on Nov. 18 _____Immediate cause of death fractured skull
Brain injury

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations NoneAutopsy results fractured skull Brain injury

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Nov 17, 1946Where did injury occur? Major Powers Ave (City or town) Salisbury (County) MD (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury Head-on collision Injured at work? no23. SIGNATURE Barriett J. Johnson M. D. or other _____Address Salisbury Md Date signed 11/19/46

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 10 1946

BUREAU V 8

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

11408

Reg. Dist. No. 339

1. PLACE OF DEATH:

County..... Wicomico
 City or town..... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 72 Years
 Hospital, institution, or street address where death occurred:
514 South Division St.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Wicomico
 City or town..... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 514 South Division St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

H. Winfred Gillis

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... divorced
 8.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... Dec. 14, 1873.
 8. AGE: Years..... 72 Months..... II Days..... I6 If less than one day..... hrs. min.

9. Birthplace..... Wicomico Co. Maryland.
 (Town, county, and state)
 10. Usual occupation..... Saleman
 11. Industry or business.....
 12. Name..... Beauchamp L. Gillis
 13. Birthplace..... Wicomico Co. Maryland.
 14. Maiden name..... Martha Anderson
 15. Birthplace..... Wicomico Co. Maryland.

16. Informant..... Mr. Herman Williams
 Address..... Salisbury, Maryland.
 17. Burial Date thereof..... 12 / 4 / 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Parsons Cemetery
 Location..... Salisbury, Maryland.

18. Funeral director..... The Hill & Johnson Co.
 Address..... Salisbury, Maryland.

19. 12/8 1946 H. H. Johnson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 30, 1946 at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical and that I last saw alive examined certified 19

Immediate cause of death..... coronary occlusion
 DURATION..... sudden death

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... none Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... for Rademacher MD M. D. or other

Address..... Salisbury Md Date signed..... 12/3/46

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DEC 11 1946
BUREAU V 8

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11409
3930

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yearsHospital, institution, or street address where death occurred: 121. Forker d.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State Wicomico County SalisburyCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 121. Forker d.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harriett Elizabeth Bladden

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife W. Bladden7. Birth date of deceased (mo., day, yr.) April 12th 18598. AGE: Years 87 Months 7 Days 12 If less than one day9. Birthplace Chance Md.
(Town, county, and state)10. Usual occupation Home wife11. Industry or business at home12. Name John Parker13. Birthplace Chance Md.14. Maiden name Harriett Jones15. Birthplace Chance Md.16. Informant Mrs. Martha WhiteAddress 121. Forker d. Salisbury Md.17. Burial Nov 26, 1946

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Rock Creek Cem.Location Chance Md.18. Funeral director William R. HallAddress Salisbury Md.19. 11/26/46

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24th 1946 at 3:05 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 24th 1946and that I last saw him Nov 24th 1946Immediate cause of death Cerebral thrombosis DURATION approx 10 minDue to Hypertension

Due to

Other conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

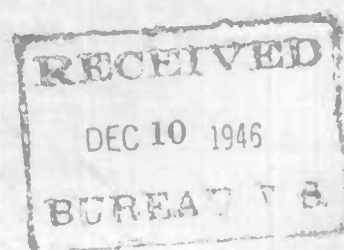
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

19. SIGNATURE John R. MaenAddress Salisbury Md.

M. D. or other

Date signed 11/26/46



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8890

1. PLACE OF DEATH
 County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 707. Poplar Hill Ave.
 Hospital, institution or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For new born infants give residence of mother)
 State MD County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 707. Poplar Hill Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Marnie Boudie Goody

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 8. (b) Name of husband or wife Bertha S. Wilkinson
 7. Birth date of deceased (mo., day, yr.) July 21 1887 6. (c) If alive, give age 58 years
 8. AGE: Years 59 Months 4 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Hebron Maryland
 (Town, county, and state)

10. Usual occupation Prisoner11. Industry or business P.R.R. Company12. Name James S. Goody13. Birthplace Hebron Maryland14. Maiden name Senna Westphal15. Birthplace Hebron Maryland16. Informant Mrs. Bertha Wilkinson GoodyAddress 707. Poplar Hill Ave. Salisbury Md.17. Burial (Burial, cremation, or removal, which?) Buried Date thereof Nov. 29 1946
 (month) (day) (year)Cemetery or crematorium Hebron CemeteryLocation Hebron Maryland18. Funeral director Halliday & Co. Walter R. HallidayAddress Salisbury Maryland19. 11/29/46 (Date rec'd by registrar)Registrar Theresa E. JohnsonAddress Salisbury Md.20. Signature John H. Yaman M.D.Address 38 Coughlin AveDate signed 11/27/4621. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18, 1946 to Nov 27, 1946and that I last saw him alive on Nov 25, 1946Immediate cause of death Coronary ThrombosisDue to Arteriosclerosis

Other conditions _____

(Include pregnancy within 8 months of death)

MEDICAL CERTIFICATION
 20. DATE OF DEATH Nov. 27 1946 at 6.4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 18, 1946 to Nov 27, 1946

and that I last saw him alive on Nov 25, 1946

Immediate cause of death Coronary ThrombosisDue to Arteriosclerosis

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John H. Yaman M.D.Address 38 Coughlin AveDate signed 11/27/46Registrar Theresa E. JohnsonAddress Salisbury Md.

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DEC 10 1946

BUREAU

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

CERTIFICATE OF DEATH



Reg. Dist. No. 3330

11411

1. PLACE OF DEATH:

County Peninsula
City or town Salisbury md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? five hours over one day
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Wicomico
City or town Newark md
(If outside city or town limits, write RURAL and give nearest town)
Street No. no
(If rural, give LOCATION)
2.(a) If veteran, name war (S) World War No. 1

3. (a) FULL NAME

James Lee Hammond

3. (b) Social Security Number

218-05-5260

4. Sex male 5. Color or race a.a. 6.(d) Single, married, widowed, or divorced single

6.(b) Name of husband or wife no 8.(c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) about 1894

8. AGE: Years 52 Months about Days about If less than one day about hrs. about min.

9. Birthplace Newark md
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business same as above

12. Name James Hammond

13. Birthplace Newark md

14. Maiden name Annie Smack

15. Birthplace Newark md

16. Informant Lambert Richards

Address Newark md

17. Burial Date thereof Nov 14-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory cedar chapel

Location Newark md

18. Funeral director James H. Stewart

Address Salisbury md

19. 11/14/46 Registrar Barrie L. Johnson

(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Nov 1946 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 Oct 1946 to 11 Nov 1946

and that I last saw h. alive on 11 Nov 1946

Immediate cause of death acute coronary thrombosis

DURATION 1 day

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Norman A. Robbins md M. D. or other

Address Newark md Date signed 12 Nov 1946

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Permanently
ACCESSION LETTER
PAS COPY

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NOV 27 1946

BUREAU V B

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11412-8380

1. PLACE OF DEATH:

County W. Comico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Penninsula General Hospital
8 days - 11 1/2 hrs.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Accomack
 City or town Wachapreague Va.
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Harrison Mr. Fred

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced widow6. (b) Name of husband or wife Lena Harrison

Deceased 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Wachapreague 1868

8. AGE: Years 78 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Wachapreague Va.
 (Town, county, and state)

10. Usual occupation Merchant11. Industry or business Merchant12. Name John William Harrison13. Birthplace Craddockville, Va.14. Maiden name Margaret Hester Wallace15. Birthplace Craddockville, Va.16. Informant Belle Haver Va.Address Virginia17. Burial Date thereof Nov. 29, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Belle Haver Va.Location Belle Haver Va.18. Funeral director Fate G. MappAddress Belle Haver Va.19. 11/6/46 19 46 Barrie E. Johnson

(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27 19 46, at 8:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/18 19 46, to 11/27 19 46and that I last saw him alive on 11/27 19 46Immediate cause of death Chy M. pneumoniaDURATION hrs

Due to _____

Due to _____

Other conditions hypertension

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Mr. M. H. M. D. or other _____Address Salisbury Date signed 11/27/46

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DEC 10 1946

PITTSBURGH

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 9990

1. PLACE OF DEATH: *McComie*
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? *98 years*
Hospital, institution, or street address where death occurred
556 S. Division St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
McComie
State..... County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No. *556 S. Division St.*
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME *James Patrick Hinchcliffe*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*
6. (b) Name of husband or wife *Mary Elizabeth Hinchcliffe*
7. Birth date of deceased (mo., day, yr.) *Jan 1 - 1892* 6. (c) If alive, give age *54* years

8. AGE: *54* Years *10* Months *2* Days It less than one day
..... hrs. min.

9. Birthplace.....
(Town, county, and state) *Newark N.J.*

10. Usual occupation..... *Carpenter*

11. Industry or business.....

12. Name..... *Hinchcliffe*

13. Birthplace..... *Newark N.J.*

14. Maiden name..... *Bantam*

15. Birthplace..... *Newark N.J.*

16. Informant..... *Mr. Mary E. Hinchcliffe*

Address..... *556 S. Div. St. Salisbury Md.*

17. Burial..... *Buried* Date thereof..... *Nov. 7 1946*
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... *McComie Mem. Park*

Location..... *Salisbury Maryland*

18. Funeral director..... *William H. Maltby R. Williams*

Address..... *Salisbury Md.*

MEDICAL CERTIFICATION
20. DATE OF DEATH..... *Nov. 3 1946* at..... *46 630 p*
21. CERTIFY that death occurred on the date above stated; that I attended deceased from..... *Nov. 2* to..... *Nov. 3*
and that I last saw him alive on..... *Nov. 2*

Immediate cause of death.....
DURATION

Due to..... *Coronary occlusion*

Due to..... *Coronary artery disease - Angina pectoris*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Persons at injury..... Injured at work?

23. SIGNATURE..... *William S. Gray M.D.*

Address..... *Salisbury Md.* Date signed..... *11/5/46*

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VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 25 1946

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-2

CERTIFICATE OF DEATH



11414

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 minutes
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 33 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 103
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Holtz, William Eric

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov -

8. AGE: Years Months Days If less than one day
hrs. 33 min.

9. Birthplace Salisbury, Ind.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Eric Holtz

13. Birthplace Salisbury, Ind.

14. Maiden name Geraldine Nelson

15. Birthplace Salisbury, Ind.

16. Informant Eric Holtz

Address Salisbury, Ind.

17. Burial Date thereof 11-9-46
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory St. E.

Location Salisbury, Ind.

18. Funeral director R. S. Grant Co.

Address Salisbury, Ind.

19. 11/9/46 Registrar Barrie L. Johnson
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1946, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19... 10... 19...
and that I last saw him alive on 19...

Immediate cause of death

1. Subarachnoid hemorrhage DURATION 10 min.
2. Hydrocephalus 10 min.

Due to

Due to

Other conditions Spina Bifida DURATION 10 min.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE N. V. Jolley, M.D. M. D. or other

Address East St. Salisbury, Ind. Date signed 11-9-46

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 22 1946
BUREAU V.B.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1600

CERTIFICATE OF DEATH

11415

Reg. Dist. No. 3350

1. PLACE OF DEATH:

County WicomicoCity or town Shaplaone Md R
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Coral Shaplaone
(If outside city or town limits, write RURAL and give nearest town)Street No. Lawson
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Storia Hopkins

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of
deceased (mo., day, yr.)Nov

8. AGE:

Years

Months

Days

If less than one day

..... hrs. 5 min.

9. Birthplace

Shaplaone Wic Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Otis Hopkins

13. Birthplace

MD

14. Maiden name

Florence Forks

15. Birthplace

MD

16. Informant

Otis Hopkins
Mardella Md R.D.

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

11-16 1946
(month) (day) (year)

Cemetery or crematory

Grave
Near Shaplaone

Location

18. Funeral director

Gravener Bros
Shaplaone

Address

19.

Nov 16
(Date rec'd by registrar)19 46Walter H. Mamm
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 1946, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

Strangulation of birth

DURATION

5 min

Due to

Birth with as attendance

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

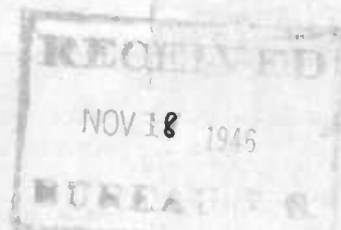
Injured at work?

23. SIGNATURE

H.S. Kallman
Shaplaone Md

M. D. or other

Address Date signed 11/16/46



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 822

CERTIFICATE OF DEATH

Reg. Diat. No. 333

★11418

1. PLACE OF DEATH: County..... <i>Salisbury</i> City or town..... <i>Salisbury</i> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death?..... <i>28 years</i> Hospital, institution, or street address where death occurred: <i>P.B. Street</i> How long in hospital or institution?.....		2. USUAL RESIDENCE (HOME) OF DECEASED: (For new born infants give residence of mother) <i>Md. McCombs</i> State..... <i>Md.</i> County..... <i>Salisbury</i> City or town..... <i>Salisbury</i> (If outside city or town limits, write RURAL and give nearest town) Street No..... <i>601. S. Division St.</i> (If rural, give LOCATION) 2.(a) If veteran, name war.....	
3. (a) FULL NAME <i>Oliver Senon Horemann</i>		3. (b) Social Security Number	
4. Sex <i>Female</i>	5. Color or race <i>White</i>	6. (a) Single, married, widowed, or divorced <i>Married</i>	
6. (b) Name of husband or wife <i>John Thomas Horemann</i>		6. (c) If alive, give age <i>69 years</i>	
7. Birth date of deceased (mo., day, yr.) <i>Oct. 24 1879</i>		8. AGE: Years..... <i>67</i> Months..... <i>0</i> Days..... <i>9</i> If less than one day.....hrs.....min.....	
9. Birthplace <i>Clara Maryland</i> (Town, county, and state)		10. Usual occupation <i>at home</i>	
11. Industry or business <i>William music</i>		12. Name <i>Clara Maryland</i>	
13. Birthplace <i>Salisbury</i>		14. Maiden name <i>McCombs</i>	
15. Birthplace <i>Md. John Thomas Horemann</i>		16. Informant <i>601. S. Division St. Salisbury Md.</i>	
17. Burial (Burial, cremation, or removal. Which?) <i>Burial</i> Date thereof..... <i>Nov 5-1946</i> (month) (year) (year) Cemetery or crematorium..... <i>Burial Church</i> Location..... <i>Salisbury Maryland</i> Funeral director..... <i>Will Gray & Co. Walter R. Horemann</i> Address..... <i>Salisbury Md.</i>		18. Burial (Burial, cremation, or removal. Which?) <i>Burial</i> Date thereof..... <i>Nov 5-1946</i> (month) (year) (year) Cemetery or crematorium..... <i>Burial Church</i> Location..... <i>Salisbury Maryland</i> Funeral director..... <i>Will Gray & Co. Walter R. Horemann</i> Address..... <i>Salisbury Md.</i>	
19. (Date rec'd by registrar) <i>11/5/46</i>		20. (Date rec'd by registrar) <i>11/5/46</i>	
21. MEDICAL CERTIFICATION 2D. DATE OF DEATH..... <i>Nov. 3 1946</i> 2E. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... <i>Oct 1946</i> to..... <i>Nov 3 1946</i> and that I last saw him/her alive on..... <i>Nov. 2 1946</i> Immediate cause of death..... <i>Thrombosis</i> Due to..... <i>Coronary Thrombosis</i> Due to..... Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury..... Injured at work? 23. SIGNATURE..... <i>William H. Gray</i> M. D. or other Address..... <i>Salisbury</i> Date signed..... <i>Nov 5 1946</i>		24. MEDICAL CERTIFICATION 2D. DATE OF DEATH..... <i>Nov. 3 1946</i> 2E. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... <i>Oct 1946</i> to..... <i>Nov 3 1946</i> and that I last saw him/her alive on..... <i>Nov. 2 1946</i> Immediate cause of death..... <i>Thrombosis</i> Due to..... <i>Coronary Thrombosis</i> Due to..... Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically. 22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury..... Injured at work? 23. SIGNATURE..... <i>William H. Gray</i> M. D. or other Address..... <i>Salisbury</i> Date signed..... <i>Nov 5 1946</i>	

RECEIVED

NOV 25 1946

BUREAU

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11416 3300

1. PLACE OF DEATH:

County Wicomico
 City or town Mardela Springs
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Mardela Springs
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rural
 (If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Claude Orville Horsey

3. (b) Social Security Number

4. Sex M. 5. Color or race Col. 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 19, 1915 8. (c) If alive, give age 31 years

8. AGE: Years 31 Months 7 Days 29 If less than one day hrs. 29 mo.

9. Birthplace Mardela, Wicomico Md.
 (Town, county, and state)

10. Usual occupation Labourer11. Industry or business Farm12. Name Robert Horsey13. Birthplace Mardela Md.14. Maiden name Edith Jefferson15. Birthplace Mardela Md.16. Informant Annie M. WalkerAddress Mardela Md.

17. Burial Date thereof 4/29/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Mardela Cpn.Location Mardela Md.18. Funeral director David E. MappedAddress Hebron Md.

19. 11/19/46 19
 (Date rec'd by registrar) Registrar W.H. Robertson

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1946 at suburban M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical 19 1946 19 1946
 and that I last saw him alive on certified 19 1946

Immediate cause of death Burns of entire body DURATION Instant death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations noneAutopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of Nov 17, 1946

Where did injury occur? Mardela Wicomico Md
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) HomeMeans of injury House caught fire - cause unknown Injured at work? no23. SIGNATURE Dr. Robert Horsey M. D. or other Dr. Robert HorseyAddress Mardela Md. Date signed 12/29/46

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BUREAU OF

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 486

CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 56 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R 720 # 2
 (If rural, give LOCATION)

2.(a) if veteran, name war

3. (a) FULL NAME

Pauline Goslee Horsey

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Carl S. Horsey 8. (c) If alive, give age 58 years
 7. Birth date of deceased (mo., day, yr.) Oct 26-1890
 8. AGE: Years 56 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Salisbury, Md R 720 2
(Town, county, and state)10. Usual occupation House work11. Industry or business Home12. Name F. Goslee Horsey13. Birthplace Wicomico County, Md14. Maiden name Eda M. Kenty15. Birthplace Sussex County, Md16. Informant Carl S. HorseyAddress Salisbury, Md17. Burial Date thereof 11-12-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory First MethodistLocation Delmar, Del18. Funeral director H. S. Grand CoAddress Delmar, DelDate rec'd by registrar November 12-46 Registrar Harry E. Hudson

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 10 19 46 at 2:45 A. M21. I CERTIFY that death occurred on the data above stated; that I attended deceased from Nov 10 19 46 to Nov 10 19 46and that I last saw him alive on Nov 9 19 46Immediate cause of death Cardiac failuredue to funeral mishap

DURATION

Due to Carcinoma of uterum 2 yrsDue to Secondary Carcinoma ofsubstantia meningiae 6 monthsOther conditions absent

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

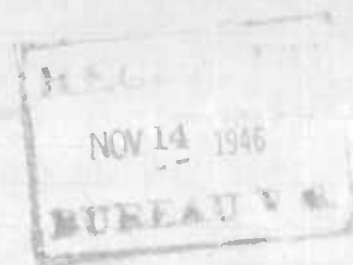
Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE STH mch M. D. or otherAddress Delmar, Del Date signed Nov 12/46



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-1

CERTIFICATE OF DEATH

Reg. Dist. No. 11419 3330

1. PLACE OF DEATH:

County.....Wicomico
City or town.....Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....33 Years
Hospital, institution, or street address where death occurred:
1411 E. Church St.
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State.....Maryland County.....Wicomico
City or town.....Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.....1411 E. Church
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

Bessie J. Hudson

4. Sex..... <u>female</u>	5. Color or race..... <u>white</u>	6. (a) Single, married, widowed, or divorced..... <u>married</u>
6. (b) Name of husband or wife..... <u>Theodore L. Hudson</u>		
6. (c) If alive, give age..... <u>55</u> years		
7. Birth date of deceased (mo., day, yr.)..... <u>Nov. 2, 1946</u> <u>1890</u>		
8. AGE: Years..... <u>56</u>	Months..... <u>0</u>	Days..... <u>17</u> hrs..... min.....
9. Birthplace..... <u>Snow Hill, Worcester, Co., Maryland</u> (Town, county, and state)		
10. Usual occupation..... <u>At Home</u>		
11. Industry or business.....		
12. Name..... <u>Richard M. Johnson</u>		
13. Birthplace..... <u>Kent Co. Del.</u>		
14. Maiden name..... <u>Patience G. Tinley</u>		
15. Birthplace..... <u>New Castle, Del.</u>		
16. Informant..... <u>Mr. Theodore L. Hudson</u> Address..... <u>Salisbury, Maryland.</u>		
17. <u>Burial</u> Date thereof..... <u>Nov. 21, 1946</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory..... <u>Whatecoat Methodist Cemetery</u> Location..... <u>Snow Hill, Maryland.</u> <u>The Hill & Johnson Co.</u> 18. Funeral director..... Address..... <u>Salisbury, Maryland.</u>		
19. <u>11/30/46</u> Registrar..... <u>Bessie J. Hudson</u> (Date rec'd by registrar)		

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Nov. 19, 1946 1015 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1946 to Nov. 19, 1946 and that I last saw her alive on Nov. 18, 1946

Immediate cause of death.....Respiratory failure
Due to.....Carcinoma Uterus DURATION.....24 mo.

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?.....

23. SIGNATURE.....Robert R. Starr
M. D. or other.....
Address.....508 N. Division Salisbury Date signed.....11-20-46

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 10 1946

BUREAU

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11420

933

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since Sept. 27, 1946
 Hospital, institution, or street address where death occurred:
E. S. Tuberculosis Sanatorium
 How long in hospital or institution? Since Sept. 27, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Sussex
 City or town (P.O.) Selbyville, Del.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

HUDSON, Helen

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife Roy Hudson

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.) June 20, 1903

8. AGE:

Years

Months

Days

If less than one day

43

4

19

hrs.

min.

9. Birthplace Worcester County, Maryland

(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

FATHER

12. Name Harry Bunting

13. Birthplace

Maryland

MOTHER

14. Maiden name Josephine Hudson

15. Birthplace

Maryland

16. Informant

self

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 12, 1946
(month) (day) (year)

Cemetery or crematory

Ebenezer Church yard

Location

near Selbyville, Del.

18. Funeral director

Henry H. Watson

Address

Pocomoke City, Md.

19.

(Date filed by registrar)

19 11/12, 19 46Barry E. Thomas
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 19 46 at 5:30 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 27 19 46 to Nov. 9 19 46and that I last saw her alive on Nov. 7 19 46

Immediate cause of death

Pulmonary Tuberculosis

DURATION

6 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Address Snow Hill, Maryland Date signed 11/9/46

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NOV 22 1946
BUREAU V. R.

2-35-

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11421

Reg. Dist. No. 9330

1. PLACE OF DEATH:

County W. Dorchester

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester

City or town Salisbury m.d.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

James Mr. John

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Assanda James

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age _____ years

1888

8. AGE:

Years

Months

Days

If less than one day

About 58 hrs. min.

9. Birthplace Georgetown Delaware
(Town, county, and state)

10. Usual occupation Chicken raiser

11. Industry or business

12. Name Thomas James

13. Birthplace Delaware

14. Maiden name Janie Phillips

15. Birthplace Delaware

16. Informant Assanda James

Address

Salisbury m.d.

17. Burial (Burial, cremation, or removal. Which?)

Date thereof Nov. 13-1946
(month) (day) (year)

Cemetery or crematory Presbyterian Cemetery Salisbury

Location Salisbury m.d.

18. Funeral director H.B. Dickinson

Address

Millsboro del.

19. 11/13 19 46

(Date rec'd by registrar)

Harrington Johnson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10-1946 at 5:25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1 19 46 to Nov 10 19 46

and that I last saw h. J.M. alive on Nov 10 19 46

Immediate cause of death

Carcinoma pancreas

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma head of pancreas

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thos. A. Insley

M. D. or other

Address Salisbury m.d. Date signed 11-13-46

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NOV 27 1946

BUREAU V. &

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 82-2

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

11422

1. PLACE OF DEATH:

County..... Wicomico
 City or town..... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2 years
 Hospital, institution, or street address where death occurred:
Salisbury, Md. R. D. 1
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Wicomico
 City or town..... Salisbury R. D. 1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

Susan A. Justice
 4. Sex..... female 5. Color or race..... white 6. (a) Single, married, widowed, or divorced..... widowed
 6. (b) Name of husband or wife..... Archie Justice
 6. (c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... Jan. 16, 1860
 8. AGE: Years..... 86 Months..... 10 Days..... 3 If less than one day..... hrs. min.

9. Birthplace..... Jenkins Bridge, Va.
 (Town, county, and state)

10. Usual occupation..... At Home

11. Industry or business.....

12. Name..... Custis Smith

13. Birthplace..... Jenkins Bridge, Va.

14. Maiden name..... Roseanne Bunting

15. Birthplace..... Jenkins Bridge, Va.

16. Informant..... Mr. Ernest F. Justice

Address..... Salisbury, Maryland. R. D. 1

17. Burial..... Nov. 23, 1946
 (Burial, cremation, or removal. Which?)
 Cemetery or crematory..... Brittingham Cemetery

Location..... Maryland and Va. Line

18. Funeral director..... The Hill & Johnson Co.

Address..... Salisbury, Maryland.

19. 11/20, 1946
 (Date rec'd by registrar) Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 19, 1946 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Nov. 19, 1946 to Nov. 19, 1946
 and that I last saw her alive on Nov. 19, 1946

Immediate cause of death..... Respiratory failure
Cerebral thrombosis DURATION..... 24 hrs.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Robert R. Starr M. D. - attester

Address..... 500 N. Division Date signed..... 11-20-46
Salisbury

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DEC 10 1946

BUREAU OF

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

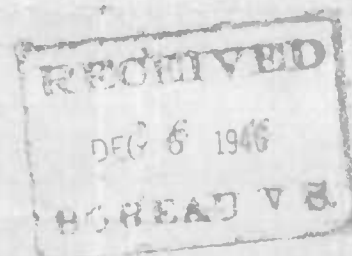
MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8370

1. PLACE OF DEATH: County... <u>Wicomico</u> City or town... <u>Tyaskin</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>Lifetime</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... <u>md.</u> County... <u>Wicomico</u> City or town... <u>Tyaskin</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) 2.(a) If veteran, name war			
3. (a) FULL NAME <u>Clara Denton Larmore</u>				3. (b) Social Security Number			
4. Sex <u>7. female</u>		5. Color or race <u>white</u>		6. (a) Single, married, widowed, or divorced <u>married</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife <u>Richard E. Larmore</u>		6. (c) If alive, give age <u>72</u> years		2D. DATE OF DEATH <u>Nov. 17</u> 19 <u>46</u> at <u>10:20pm</u>		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>November 1 - 1946 to Nov. 15 - 1946</u> and that I last saw him alive on <u>Nov. 15 - 1946</u>	
7. Birth date of deceased (mo., day, yr.) <u>May 5 - 1876</u>		8. AGE: Years <u>70</u> Months <u>6</u> Days <u>12</u> If less than one day hrs. min.		Immediate cause of death <u>Coronary heart disease</u>		DURATION	
8. Birthplace <u>Tyaskin, Wicomico, Md.</u> (Town, county, and state)		10. Usual occupation <u>Housewife</u>		Due to		Due to	
11. Industry or business		12. Name <u>William F. Denton</u>		13. Birthplace <u>Bedford City, England</u>		Other conditions <u>Arteriosclerosis</u> (Include pregnancy within 3 months of death)	
14. Maiden name <u>Rosea Jane Impley</u>		15. Birthplace <u>Tyaskin, Md.</u>		Major findings of operations		Date of op.	
16. Informant <u>Richard Larmore</u> Address <u>Tyaskin, Md.</u>		17. Burial (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>11/20/46</u> (month) (day) (year) Cemetery or crematory <u>Tyaskin Cemetery</u> Location <u>Tyaskin, Md.</u>		Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.		22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of Injury Injured at work?	
18. Funeral director <u>E. S. Messick</u> Address <u>Bivalve, Md.</u>		19. Nov 19 46 R. Bedford Thelton (Date rec'd by registrar) Registrar		23. SIGNATURE <u>William F. Denton</u> Address <u>H. Clark - Md.</u> Date signed <u>Nov 19 - 46</u> M. D. or other			



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 335

1. PLACE OF DEATH:

County Wilcomica
 City or town Sharptown md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Wilcomica
 City or town Sharptown md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. no
 (If rural, give LOCATION)
 2.(a) If veteran, name war no

3. (a) FULL NAME

Williams A Mc Glatton
 4. Sex male 5. Color or race A.A. 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Emma M Mc Glatton
 7. Birth date of deceased (mo., day, yr.) Feb 26 1883
 6.(c) If alive, give age Don't know years
 8. AGE: Years 63 Months Days If less than one day
 hrs. min.

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1946 at 9:58 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1942 to Nov 4 1946and that I last saw him alive on Nov 3 1946Immediate cause of death Cervicovaginal Prostate

DURATION

3 1/2 years

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

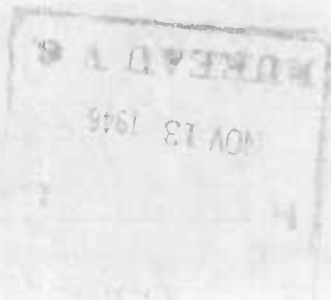
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. S. KuhlmanAddress Sharptown md Date signed 11/8/46

9. Birthplace Sharptown md
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business Same as above
 12. Name James Mc Glatton
 13. Birthplace Harlock md
 14. Maiden name Harrett E Gaine
 15. Birthplace Sharptown md
 16. Informant Andrew Mc Glatton
 Address Salisbury md
 17. Burial Burial Date thereof Nov 10 - 46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Sharptown
 Location Sharptown md
 18. Funeral director James Stewart
 Address Salisbury md
 19. 11/13 1946 A. H. Hedrich
 (Date rec'd by registrar) Registrar



COPY SENT TO County REGISTRAR NO. _____ DATE 11/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

CERTIFICATE OF DEATH

11466

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural 2
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William S. Parker

3. (b) Social Security Number

219-07-7152

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married8. (b) Name of husband or wife Gladys V. Parker6. (c) If alive, give age 44 years

7. Birth date of

deceased (mo., day, yr.)

Aug. 19, 1902

8. AGE:

Years

Months

Days

If less than one day

44226

hrs.

min.

9. Birthplace Salisbury, Wicomico Co. Maryland
(Town, county, and state)10. Usual occupation Salesman11. Industry or business farm implement supplies

FATHER

12. Name

Billy H. Parker

13. Birthplace

Wicomico Co. Maryland.

MOTHER

14. Maiden name

Rosa Nicholson

15. Birthplace

Wicomico Co. Maryland16. Informant Mrs William S. ParkerAddress Salisbury, Maryland. R. D. 217. Burial
(Burial, cremation, or removal. Which?)Date thereof Nov. 16, 1946
(month) (day) (year)Cemetery or crematory Parsons CemeteryLocation Salisbury, Maryland18. Funeral director The Hill & Johnson Co.Address Salisbury, Maryland19. 11/16,
(Date rec'd by registrar)19. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 4619. 46

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1946, at 5:13 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 819. 46

to

19. 46

and that I last saw him alive on

19. 46

Immediate cause of death

Cardiac failure

DURATION

36 hrs.

Due to

Coronary Perforation

Due to

Perforated appendix6 days

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Perforated appendix -
ggn. perforationDate of op. 11/8/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William B. Long M.D.

M. D. of other

Address

504 N. Division St.
Salisbury, Md.Date signed 11/16/46

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NOV 27 1946

BUREAU V 8

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17004

CERTIFICATE OF DEATH

11426

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 minutes
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. SP 720 3
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Reddish, Mrs. Paul

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

8. (b) Name of husband or wife. Elton Reddish

6. (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Aug 19 - 1907

8. AGE: Years 39 Months Days If less than one day

9. Birthplace. Delmar, Del. (Town, county, and state)

10. Usual occupation. Farmer

11. Industry or business. Farm

12. Name. C. W. Reddish

13. Birthplace. Delmar, Del.

14. Maiden name. Mamie Corday

15. Birthplace. Delmar, Del.

16. Informant. Elton Reddish

Address. Delmar, Del.

17. Burial Date thereof. 11-13-46 (month) (day) (year)

Cemetery or crematory. P. P.

Location. Delmar, Del.

18. Funeral director. P. S. Grand Co.

Address. Delmar, Del.

19. 11/13/46 Date of registration

MEDICAL CERTIFICATION

20. DATE OF DEATH. Nov 10 1946 at 6:10 P M

21. I CERTIFY that death occurred on the date above stated; that ~~deceased~~ deceased from

and that I last saw him alive on

Immediate cause of death

Broken neck & fractured skull

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy result

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. accident Date of 11/10/46

Where and injury occur? Delmar, Del. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public place

Means of injury Motorcycle Injured at work? no

23. SIGNATURE. Dr. H. L. Loughford M.D.

Address. Delmar, Del. Date signed 11/13/46

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20535

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NOV 27 1946
BUREAU V. B.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16-2

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County..... Wicomico
 City or town..... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Worcester
 City or town..... Berlin
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Alice May Richardson

3. (b) Social Security Number

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....
 8. AGE: Years..... Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial Date thereof.....

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. 11/8/46 19. 46 Registrar.....

(Date rec'd by registrar) (month) (day) (year)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 6 19 46, at 3:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death..... Fractured skullDURATION..... 8 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... accident Date of..... Oct 28 '46Where did injury occur?..... Berlin Worcester Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?)..... HomeMeans of injury..... Fall out door, Injured at work? no23. SIGNATURE..... John L. Riley M.D.Address..... 106/46Date signed..... 10/6/46

NOV 22 1946
BUREAU F.B.I.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89-57

CERTIFICATE OF DEATH

Reg. Dist. No. 9330

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital
How long in hospital or institution? 43 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County SussexCity or town Frankford, Del.
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F. Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Rust, Sandra Sue

3.(b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Infant

8.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) May 17, 1946 8.(c) If alive, give age - years8. AGE: Years 5 Months 17 Days - If less than one day - hrs. - min.9. Birthplace Salisbury, Md.
(Town, county and state)

10. Usual occupation

11. Industry or business

12. Name Linford P. Rust13. Birthplace Wilmington, Delaware14. Maiden name Margie Lucille15. Birthplace Wilmington, Md.16. Informant Linford RustAddress Frankford, Del.17. Burial Date thereof Nov 5 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory New HopeLocation Wilmington, Md.18. Funeral director M. Pashu WatsonAddress Salisbury, Delaware19. 11/6/46 Registrar Barriett Johnson

(Date recorded by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1946 at 8:24 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 2, 1946 to Nov 4, 1946and that I last saw him alive on Nov 3, 1946

Immediate cause of death

meningitis

DURATION

3 daysDue to otitis purulent4 daysOther conditions acute meningococci from culture spinal fluid + blood culture report not been reported

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. W. W. M. D.Address Salisbury Date signed Nov 4

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NOV 25 1946

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 870

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Gen. Sew. Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Lanset
 City or town Pr. Anne, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Smith, Mrs. Katie

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White ~~married~~ widowed

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) 8. (c) If alive, give age _____ years

Jan 16, 1876

8. AGE: Years Months Days If less than one day
70 _____ hrs. _____ min.9. Birthplace Peoria, Illinois
(Town, county, and state)10. Usual occupation housewife

11. Industry or business _____

12. Name Ferdinand Hoffman13. Birthplace Honover, Germany14. Maiden name Mary Smith15. Birthplace Daniger, Germany16. Informant Grace Moore DrydenAddress Princess Anne17. burial Date thereof Nov 20, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory EpiscopalLocation Pr. Anne, Md.16. Funeral director Dale DarshellAddress Princess Anne, Md.19. 11/19 19 46 Harriet E. Johnson
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18, 1946 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ to _____

and that I last saw her alive on 8:30 pm - Nov 18, 1946

Immediate cause of death _____ DURATION _____

Parkinson's Disease NeuroDue to Generalizedarteriosclerosis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Ther. B. Lee, Jr. M. D. or other _____Address Princess Anne Date signed 11/19/46

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 27 1946

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11429

Reg. Dist. No. 2930

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Penninsula General Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset
 City or town Princess Anne
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

Stewart James

3. (b) Social Security Number

4. Sex Male 5. Color or race C 6. (a) Single, married, widowed, or divorced ✓

B. (b) Name of husband or wife Mar Stewart

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age _____ years

8. AGE: Years 49 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Somerset County Md
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name William J Stewart13. Birthplace Md.14. Maiden name Olivia Mulhorne15. Birthplace Md.16. Informant Walter StewartAddress Princess Anne Md

17. Burial Date thereof 12/2/46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Marks ChurchLocation Oakville, Md18. Funeral director William A. James JrAddress Princess Anne, Md.19. 12/3/46 Barrie L. Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1946 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/27 1946 to 11/29 1946and that I last saw him alive on 11/28 1946Immediate cause of death Cerebral Hemorrhage

DURATION

2 daysDue to (2)

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

3. SIGNATURE Clarence J. Franks, M.D.

M. D. or other

Address Salisbury Md Date signed 11/29/46

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

15311

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D.C. 20315

Transmitted

25 JAN 1946

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RECEIVED
DEC 11 1946
BUREAU V B

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1400

CERTIFICATE OF DEATH



11430

Reg. Dist. No. 339

1. PLACE OF DEATH:

County W. Cornico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Penninsula General Hospital
 How long in hospital or institution? 24 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County ...
 City or town ...
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ...
 (If rural, give LOCATION)
 2(a) If veteran, name war ...

3. (a) FULL NAME

Sutcliffe

3. (b) Social Security Number

4. Sex 5. Color of face 6. (a) Single, married, widowed, or divorced

male white

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Nov. 1946 6. (c) If alive, give age 24 years

8. AGE: Years Months Days 24 hrs. min.

9. Birthplace Md.
(Town, county, and state)10. Usual occupation Cabinet maker

11. Industry or business

12. Name Sutcliffe Richard Starr
 13. Birthplace Brooklyn New York
 14. Maiden name Mary Evelyn Donkany
 15. Birthplace Parsonburg Md.

16. Informant

Address

17. (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory Penninsula General Hospital
 Location Salisbury, Maryland

18. Funeral director

Address

19. 11/19/46 Registrar Barry L. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1946 at 7:18 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 18, 1946 to Nov. 19, 1946
 and that I last saw him alive on Nov. 19, 1946

Immediate cause of death

PREMATURITY
Due to
ABRUPTIO PLACENTA
Due to

Other conditions

PREMATURE LABOR (PREG 6 mths)
 (Include pregnancy within 3 months of death)

Major findings of operations

none Date of op. ...

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Did injury occur? City or town (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

J. Rivers Housley, M.D.
 Address Salisbury, MD Date signed 11/19/46

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NOV 27 1946
BUREAU V.B.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11431

1700

Reg. Dist. No. 3990

1. PLACE OF DEATH:

County W. Cornies
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

14 hrs. 10 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Neomies
 City or town Fruitland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Chatham St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Taylor Mr. George Washington

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

✓

6. (b) Name of husband or wife

Mrs. Dorothy M. Taylor

7. Birth date of deceased (mo., day, yr.)

Nov. 24 - 1893

8. AGE:

Years 51Months 0Days 2

If less than one day

hrs.

min.

9. Birthplace

Neomies C. Md.
(Town, county, and state)

10. Usual occupation

Prop. 4

11. Industry or business

Retiree

FATHER

12. Name

William Taylor

13. Birthplace

Ocean View Del.

MOTHER

14. Maiden name

Elinor Parker

15. Birthplace

Neomies C. Md.

16. Informant

Mrs. Dorothy M. Taylor

Address

Chatham St. Fruitland Md.

17.

Burial

Date thereof

Nov. 29 - 46

(Burial, cremation, or removal, which?)

Cemetery or crematory

Palmer's Cem.

Location

Salisbury Md.

18. Coroner or director

W. M. G. + G. Walter R. Williams

Address

Salisbury Md.

19.

11/29/46

(Date filed by Registrar)

19.

46Barrett E. Johnson

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Nov. 25 -1946, at 7:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw medical certificate alive on 19

Immediate cause of death

Excussion of brain
Retained Hemorrhage
Fractured R. Ilium
Fractured R. Radius + Ulna

DURATION

12 hrs.

Due to

Other conditions

Retained R. Kidney

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide accident Date of 11/25/46Where did injury occur? Fruitland Neomies Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury walked in front of truck Injured at work? No

23. SIGNATURE

Barrett E. Johnson

M. D. or other

Address

Salisbury Md.Date signed 11/25/46

ARTIST ANN L. B. B.

PRAG CONTENT

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DEC 10 1946
BUREAU 8

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11432

Reg. Dist. No. 3310

1. PLACE OF DEATH:

County..... *Wicomico*
 City or town..... *Delmar*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... *23 yrs.*
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... *MD* County..... *Wicomico*
 City or town..... *Delmar*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

David Ashmal Webster

3. (b) Social Security Number

4. Sex

Male

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Married

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *11/27/46* 19....., at *2:30 PM*

6. (b) Name of husband or wife

*Dorothy Humphries Webster*6. (c) If alive, give age..... *30* years

7. Birth date of deceased (mo., day, yr.)

Sept. 11, 1866

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

Deale Island, Somerset, Md.
(Town, county, and state)

10. Usual occupation.....

Farming

11. Industry or business.....

12. Name.....

James Webster

13. Birthplace.....

Deale Island Md.

14. Maiden name.....

Clara J. Webster

15. Birthplace.....

Deale Island Md.

16. Informant.....

Mrs. Dorothy Webster

Address.....

Delmar Md.

17. Burial.....

Burial

(Burial, cremation, or removal, which?)

Date thereof..... *11/29/46*

Cemetery or crematory.....

Delmar Cemetery

Location.....

Delmar Md.

18. Funeral director.....

David H. Mesnick

Address.....

*Delmar Md.*19. *Nov 29 1946*M.D. *Mrs J. M. Wallace*

Registrar

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Nov. 1946* to *Nov. 26 1946*and that I last saw him alive on *Nov. 26 1946*Immediate cause of death..... *cerebral hemorrhage*

Due to.....

Due to.....

Other conditions..... *arteriosclerosis*

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... *W. William Furches*Address..... *Delmar - Md.* Date signed..... *Nov. 29 46*

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BtB)

CERTIFICATE OF DEATH

Reg. Dist. No.

11433

33/0

1. PLACE OF DEATH: *Nicomis*
 County *Mandela*
 City or town *23 yrs*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
R.O. #1
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants, give residence of mother)
md Nicomis
 State *Mandela* County
 City or town *R.O. #1*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *R.O. #1*
 (if rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME *Elizabeth Wesley*

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widow*
 6. (b) Name of husband or wife *Cell H. Wesley*
 6. (c) If alive, give age *Dead*

7. Birth date of deceased (mo., day, yr.) *June 28, 1882*
 8. AGE: *64* Years *4* Months *4* Days If less than one day
 hrs. min.

9. Birthplace *Detroit Mich*
 (Town, county, and state)
Home Ap

10. Usual occupation

11. Industry *Business*

12. Name *Fredrick Pearson*

13. Birthplace *Mich.*

14. Maiden name *Unknown*

15. Birthplace

16. Informant *Harold Cell Wesley*

Address *R.O. #1, Mandela*

17. Burial *Nov 23rd 1946*

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematorium *Salisbury Cem.*

Location *Salisbury Md*

18. Funeral director *Hollings & Co. Walter R. Hollings*

Address *Salisbury Md*

19. *Nov 23* 19 *46* *Mrs J M. Walker*

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov. 21st* 19 *46* at *4:125P* M

I. I CERTIFY that death occurred on the date above stated; that I attended deceased from *October 1st* 19 *46* to *Nov 21st* 19 *46*
 and that I last saw him alive on *Nov 21st* 19 *46*

Immediate cause of death *Chronic Myocarditis*

DURATION

Due to

Due to

Other conditions *Chronic Nephritis*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

21. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

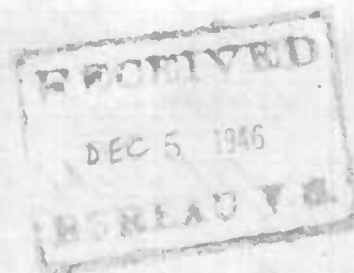
Injured at home, farm, industry, public place (where?)

Years of injury Injured at work?

23. SIGNATURE *William E. Smith*

M. D. or other

Address *Helsre - Md* Date signed *Nov 22 46*



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

11434
★ Reg. Dist. No. 3290

1. PLACE OF DEATH:

County Wicomico
 City or town Siloam
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 85 Years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Salisbury R. D. I
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Siloam
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

Arianna Wheatley

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Capt. Henry Charles Wheatley

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1861

8. AGE: Years 85 Months 0 Days 30 It less than one day hrs. min.

9. Birthplace Wicomico, Co. Maryland.
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

MOTHER FATHER 12. Name Beauchamp White

13. Birthplace Maryland

14. Maiden name Mary Banks

15. Birthplace Maryland

16. Informant Mr. Wm. Wheatley
Address Salisbury, Maryland. R.D. I

17. Burial Date thereof 11/26/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Siloam Cemetery

Location Siloam, Md.

18. Funeral director The Hill & Johnson Co.
Address Salisbury, Md.

19. 11/26/46 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1946 19..... 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to Nov 24 1946 and that I last saw him alive on Nov 20 1946

Immediate cause of death Chronic myocarditis

DURATION 2

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Harmon M. H. M. D. or other
 Address Salisbury Date signed Nov 25

MARGIN RESERVED FOR BINDING

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11435

Reg. Dist. No. 3930

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

P.O. #1. Farmington

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 1205 N. Main St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Charlie Marion White

3. (b) Social Security Number

4. Sex

Male

5. Color of face

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Nalia C. Mills White

7. Birth date of

deceased (mo., day, yr.)

Aug. 20 - 18846. (c) If alive, give age 52 years

8. AGE:

Years

Months

Days

If less than one day

62218

hrs.

min.

9. Birthplace

Wicomico Co. Md.

(Town, county, and state)

10. Usual occupation

Merchant

11. Industry or business

Green store

12. Name

MOTHER

FATHER

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Date thereof

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

19. Date signed

19. Date signed

19. Date signed

19. Date signed

19. Date signed

19. Date signed

19. Date signed

19. Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1946 at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

deceased 1946 to 1946and that I last saw him alive on 1946

Immediate cause of death

Cerebral thrombosis

Due to

Cerebral hypoperfusion

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work?

23. SIGNATURE

Glenn J. Fisher M. D. or otherAddress Salisbury MarylandDate signed 11/8/46

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 370

CERTIFICATE OF DEATH

11436

Reg. Dist. No. 999

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Eleven Days
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? Eleven Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Somerset
City or town Romney Quarter Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. no
(If rural, give LOCATION)
2.(a) If veteran, name war no ✓

3. (a) FULL NAME

Gertrude A. White

3. (b) Social Security Number

Lost

4. Sex female 5. Color or race a. a 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Willie White
yes no 6. (c) If alive, give age na years

7. Birth date of deceased (mo., day, yr.) yes 1896

8. AGE: Years 50 Months 0 Days 0 If less than one day 0 hrs. 0 min.

9. Birthplace Romney Quarter Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same as above

12. Name Jessie Elzy

13. Birthplace Romney Quarter Md

14. Maiden name Lattie Curtis

15. Birthplace Romney Quarter Md

16. Informant Clyde White

Address Salisbury Md

17. Burial Date thereof Nov 8-46
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Romney Quarter

Location Romney Quarter Md

18. Funeral director James H. Stewart

Address Salisbury Md

19. 11/8 19 46 Harriet G. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5th 1946 at 8:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to 11/5 19 46
and that I last saw him or alive on 11/4 19 46

Immediate cause of death Encephalitis Letargica DURATION 2 weeks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Claude S. Fincher M. D. or other

Address Salisbury Md Date signed 11/6/46

MARGIN RESERVED FOR BINDING

I

VS A15 9.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11437

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 34 years
 Hospital, institution, or street address where death occurred:
307 Mitchell St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 307 Mitchell St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Irene Williams

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife George H. Williams
 6.(c) If alive, give age 77 years
 7. Birth date of deceased (mo., day, yr.) Feb. 1, 1874
 8. AGE: Years 72 Months 8 Days 18 It less than one day _____ hrs. _____ min.

9. Birthplace Wicomico Co. Maryland
 (Town, county, and state)
 10. Usual occupation at home
 11. Industry or business
 12. Name David Field
 13. Birthplace Wicomico Co. Maryland
 14. Maiden name Alverta Smith
 15. Birthplace Wicomico Co. Maryland

16. Informant Mr. George H. Williams
 Address Salisbury, Maryland
 17. Burial Date thereof Nov. 3, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Shad Point Methodist Cemetery
 Location Shad Point, Maryland
 18. Funeral director The Hill & Johnson Co.
 Address Salisbury, Maryland

19. 11/13, 1946 Registrar Harriet E. Johnson
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1946 at 2:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/22 1946 to 11/1 1946
 and that I last saw him or alive on 11/1 1946

Immediate cause of death myocarditis DURATION several years

Due to _____

Due to _____

Other conditions fracture of left hip 10 days

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10/22/46Where did injury occur? Salisbury (City or town) Wicomico (County) MD (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury fall Injured at work? no23. SIGNATURE Oliver F. Fischer M. D. or otherAddress Salisbury, Md Date signed 11/24/46

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11438

Reg. Dist. No. 9330

1. PLACE OF DEATH:

County..... WicomicoCity or town..... Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... 64 years

Hospital, institution, or street address where death occurred:

Virginia Ave & Riverside Road

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... WicomicoCity or town..... Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No..... Virginia Ave at Riverside Road
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Elizabeth W. Woodcock

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

femalewhitesingle

6. (b) Name of husband or wife.....

B. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1881.8. AGE: Years..... Months..... Days..... If less than one day
64 11 24 hrs. min.9. Birthplace..... Salisbury, Wicomico, Co. Md.
(Town, county, and state)10. Usual occupation..... Retired11. Industry or business..... School Teacher12. Name..... Amos Wilson Woodcock13. Birthplace..... Pennsylvania14. Maiden name..... Julia Ann Harrison Wright15. Birthplace..... Maryland.16. Informant..... Gen. A. W. W. WoodcockAddress: Salisbury, Maryland17. Burial Date thereof..... Nov. 16, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Parsons CemeteryLocation..... Salisbury, Maryland.18. Funeral director..... The Hill & Johnson Co.Address..... Salisbury, Maryland.19. 11/16, 19 46 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 14, 1946 19..... 515 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1945 to Nov 14th 1946
and that I last saw her alive on 11/14 1946

Immediate cause of death.....

Carcinoma of Rectum

DURATION

21 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

Clara Fisher

M. D. or other

Address..... Salisbury Md. Date signed..... 11/16/46

MARGIN RESERVED FOR BINDING

VS A15 9-4-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 27 1946
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